Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BEAUMONT HOME HEALTH SERVICE
2350 BROADWAY ST
BEAUMONT TX 77702-2004

Respondent Name
THE GRAY INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-05-6892-01

MFDR Date Received
April 19, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Corrected pre-authorization number provided on UB92"

Amount in Dispute: $525.04

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2005 to January 31, 2005	Home Health Services	$525.04	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out requirements related to preauthorization of health care.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. This request for medical fee dispute resolution was received by the Division on April 19, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on May 10, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 62 – Payment denied since you failed to obtain preauthorization for treatment(s) and/or service(s) that require preauthorization.
   - 18 – Duplicate claim/service.

Findings

1. The respondent denied disputed services with reason code 62 – "Payment denied since you failed to obtain preauthorization for treatment(s) and/or service(s) that require preauthorization." 28 Texas Administrative Code §134.600(b)(1)(B) states, in pertinent part, that the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (h) or (i) of this section, only when "preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care." The services listed in subsection (h)(12) include "convalescent, residential, and all home health care services and treatments." The services in dispute are home health/skilled nursing services supplied at the home of the injured worker. The disputed services are therefore services for which preauthorization is required prior to providing the health care. Review of the submitted documentation finds that the requestor submitted a pre-authorization request for 7 days of skilled nursing visits. The request was approved with preauthorization number 558167. While the pre-authorization notes that certain changes to the preauthorization request were recommended, 28 Texas Administrative Code §134.600(f)(8) provides that the carrier shall "not condition an approval or change any elements of the request as listed in subsection (e)(2), unless the condition or change is mutually agreed to by the health care provider and carrier and the agreement is documented." No documentation was found to support that the recommended condition or change was mutually agreed to by the health care provider and carrier; therefore the Division finds that the disputed services were authorized as originally requested by the health care provider, without any condition or change as recommended by the authorization reviewer. Seven visits were authorized. Five visits are in dispute. No documentation was found to support that the health care provider exceeded the authorized number of visits. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed for payment according to applicable Division rules and fee guidelines.
2. This dispute relates to services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Former 28 Texas Administrative Code §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not discuss how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iii).
5. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor did not submit a position statement for consideration in this dispute.
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	November 1, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.